



## General

### Guideline Title

Primary care behavioral interventions to reduce illicit drug and nonmedical pharmaceutical use in children and adolescents: U.S. Preventive Services Task Force recommendation statement.

### Bibliographic Source(s)

U.S. Preventive Services Task Force. Primary care behavioral interventions to reduce illicit drug and nonmedical pharmaceutical use in children and adolescents: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med.* 2014 May 6;160(9):634-9. [12 references] [PubMed](#)

### Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: U.S. Preventive Services Task Force (USPSTF). Screening for illicit drug use: U.S. Preventive Services Task Force recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2008 Jan. 7 p.

This guideline meets NGC's 2013 (revised) inclusion criteria.

## Recommendations

### Major Recommendations

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and identifies the Levels of Certainty regarding Net Benefit (High, Moderate, and Low). The definitions of these grades can be found at the end of the "Major Recommendations" field.

#### Summary of Recommendation and Evidence

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of primary care–based behavioral interventions to prevent or reduce illicit drug or nonmedical pharmaceutical use in children and adolescents. This recommendation applies to children and adolescents who have not already been diagnosed with a substance use disorder. (I statement)

See the Clinical Considerations section for suggestions for practice regarding the I statement and definitions of terms that are used.

#### Clinical Considerations

##### Patient Population Under Consideration

This recommendation applies to children and adolescents younger than age 18 years. It does not apply to children and adolescents who have been

diagnosed with a substance use disorder. All persons with a substance use disorder should receive appropriate treatment. Although this statement does not include a recommendation on screening for drug use, further information on screening tests is provided in the Discussion section.

## Definitions

The USPSTF recognizes that various definitions have been applied to the terms *drug use*, *misuse*, and *abuse*. For the purpose of this recommendation statement, "drug use" encompasses the general concepts of "illicit drug use" and "nonmedical use of pharmaceuticals" (prescription and over-the-counter drugs). "Illicit drug use" specifies use of illegal drugs (such as cocaine and heroin) and inhalants (such as aerosols, glue, and gasoline). "Nonmedical use of pharmaceuticals" includes the use of prescribed medications for a purpose other than prescribed (or by a person not prescribed the medication) or the use of over-the-counter drugs for a purpose other than medically indicated. To be consistent with the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, "substance use disorder" is used instead of "substance abuse" and "substance dependence" unless describing previously collected study or survey results that reported findings using the terms *abuse* and *dependence*.

## Behavioral Interventions

Although the evidence to recommend specific interventions in the primary care setting is insufficient, interventions that have been studied include face-to-face counseling, videos, print materials, and interactive computer-based tools. Studies on these interventions provide little to no evidence of significant improvements in health outcomes.

## Suggestions for Practice Regarding the I Statement

In deciding whether to provide behavioral interventions to prevent or reduce illicit drug and nonmedical pharmaceutical use for children and adolescents, primary care providers should consider the following factors.

### *Potential Preventable Burden*

According to the National Survey on Drug Use and Health (NSDUH), nearly 1 in 10 U.S. adolescents use drugs. In 2011, the Drug Abuse Warning Network estimated that more than 75,000 emergency department visits by children and adolescents involved illicit drugs, and more than 75,000 visits involved the nonmedical use of pharmaceuticals. The consequences of drug use include risk for progression to a substance use disorder, an increase in risk-taking behaviors while under the influence, and lower educational achievement and attainment. Persons who initiate marijuana use at younger ages are more likely to progress to drug abuse and dependence as adults compared with those who initiate use after age 18 years.

### *Costs*

The costs associated with primary care-based behavioral interventions vary substantially and are similar to costs of interventions for tobacco and alcohol reduction. Health systems and providers should account for the staff time associated with any intervention, which may range from distributing educational materials to a series of office-based, 1-on-1 counseling sessions. Computer-based interactive tools linked to an adolescent's personal health record may require less ongoing staff time to administer. There are also potential costs for families, especially for interventions that require significant participation from parents as well as adolescents.

### *Potential Harms*

Potential harms associated with behavioral interventions include anxiety, interference with the clinician-patient relationship, opportunity costs (that is, time spent on these interventions that could be used for other, more effective interventions), unintended increases in other risky behaviors, and even paradoxical increases in drug use or initiation. Although evidence is limited, no direct harms were identified.

### *Current Practice*

Most clinicians who care for children and adolescents in the United States do not provide behavioral interventions to reduce drug use. Given the lack of evidence of effective primary care-based interventions, this is not surprising. It is important to recognize that this recommendation does not address screening for drug use. Screening adolescents who are not suspected to be using drugs may identify some who meet criteria for a substance use disorder and for whom treatment is available. The Task Force did not find effective interventions to reduce future drug use in adolescents who have tried illicit drugs.

### *Useful Resources*

The USPSTF has made recommendations on screening for and interventions to decrease the unhealthy use of other substances, including alcohol and tobacco. These recommendations are available on the [USPSTF Web site](#) .

## Definitions:

## What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer/provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer/provide this service.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer/provide this service only if other considerations support offering or providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see the "Major Recommendations" field). If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

### USPSTF Levels of Certainty Regarding Net Benefit

Definition: The USPSTF defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	<p>The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as:</p> <ul style="list-style-type: none"> <li>• The number, size, or quality of individual studies</li> <li>• Inconsistency of findings across individual studies</li> <li>• Limited generalizability of findings to routine primary care practice</li> <li>• Lack of coherence in the chain of evidence</li> </ul> <p>As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.</p>
Low	<p>The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of:</p> <ul style="list-style-type: none"> <li>• The limited number or size of studies</li> <li>• Important flaws in study design or methods</li> <li>• Inconsistency of findings across individual studies</li> <li>• Gaps in the chain of evidence</li> <li>• findings not generalizable to routine primary care practice</li> <li>• a lack of information on important health outcomes</li> </ul>

Level of Certainty	Description More information may allow an estimation of effects on health outcomes.

## Clinical Algorithm(s)

None available

## Scope

### Disease/Condition(s)

Illicit drug and nonmedical pharmaceutical use

### Guideline Category

Prevention

Screening

### Clinical Specialty

Family Practice

Nursing

Pediatrics

Preventive Medicine

### Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Nurses

Physician Assistants

Physicians

Public Health Departments

### Guideline Objective(s)

- To summarize the U.S. Preventive Services Task Force (USPSTF) recommendation and supporting scientific evidence on behavioral interventions for illicit drug use
- To update the 2008 USPSTF recommendations on screening for illicit drug use

### Target Population

Children and adolescents younger than age 18 years who have not been diagnosed with a substance use disorder

## Interventions and Practices Considered

1. Face-to-face counseling
2. Videos
3. Print materials
4. Interactive computer-based tools

## Major Outcomes Considered

- Key Question 1: Do primary care behavioral counseling interventions for drug use, with or without referral, improve mortality, morbidity, and other health, social, and legal outcomes in children and adolescents?
  - a. Do outcomes differ in subgroups (e.g., as defined by age, risk level, sex, race, ethnicity, or types of substances used)?
  - b. What are elements of efficacious interventions?
  - c. What criteria are used to identify children and adolescents for primary care drug use interventions?
- Key Question 2: Do primary care behavioral counseling interventions for drug use, with or without referral, prevent drug use initiation in children and adolescents who do not currently use drugs or reduce drug use in children and adolescents who currently use drugs?
  - a. Do outcomes differ in subgroups (e.g., as defined by age, risk level, sex, race, ethnicity, or types of substances used)?
  - b. What are elements of efficacious interventions?
  - c. What criteria are used to identify children and adolescents for primary care drug use interventions?
- Key Question 3: What are the adverse events of primary care behavioral counseling drug use interventions?

## Methodology

### Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Searches of Unpublished Data

### Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Kaiser Permanente Research Affiliates Evidence-based Practice Center (EPC), Center for Health Research, for the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Data Sources and Searches

EPC staff searched for English-language publications in PubMed, PsycINFO, and the Cochrane Central Register of Controlled Trials from January 1992 through 4 June 2013 and in MEDLINE through 31 August 2013. EPC staff also assessed the 2 trials that were specific to children and adolescents and were included in the 2008 review. EPC staff examined the reference lists of 6 relevant published reviews and meta-analyses, as well as the reference lists of included studies. EPC staff considered gray literature sources and recommendations from experts.

Study Selection

Two investigators independently reviewed abstracts against prespecified eligibility criteria. EPC staff dually reviewed all full-text articles for potential inclusion. EPC staff included randomized, controlled trials (RCTs) or controlled clinical trials designed to prevent or reduce drug use in children and adolescents (aged <18 years [no lower age restriction]) who were not diagnosed with a substance use disorder or seeking treatment

for substance misuse. EPC staff included trials conducted in primary care or those that tested interventions that were judged feasible for conduct in primary care that had a link to a health care setting or system, with or without referral to specialty treatment services. This included interventions employing the full SBIRT model and other approaches to primary prevention (to prevent initiation of use) or tertiary prevention (to prevent continued use and adverse effects in those already using). EPC staff also included interventions delivered exclusively through electronic media (such as the Internet or CD-ROMs) that were not linked to health care. They excluded trials among youths diagnosed with substance abuse or dependence because they represented specialty treatment only. They also excluded studies conducted among adolescents who were mandated or directly referred to substance abuse or dependence treatment via the juvenile justice system, social services, parents, or a similar referral system. In addition, EPC staff excluded interventions conducted in substance abuse treatment centers, schools, worksites, and other institutions (for example, juvenile detention centers). Included trials had control groups that offered minimal or no treatment and reported drug use or health or social outcomes at least 6 months after baseline.

## Number of Source Documents

- Key Question 1: 5 relevant articles were identified, including 4 studies
- Key Question 2: 7 relevant articles were identified, including 6 studies
- Key Question 3: No relevant articles were identified.

## Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

## Rating Scheme for the Strength of the Evidence

Two investigators independently assessed the quality of all trials meeting the inclusion criteria, resulting in a rating of "good," "fair," or "poor" (see Appendix A in the Evidence Synthesis [see the "Availability of Companion Documents" field] for quality criteria).

## Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

## Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Kaiser Permanente Research Affiliates Evidence-based Practice Center (EPC), Center for Health Research, for the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Data Extraction and Quality Assessment

Two independent investigators rated the quality of all included trials as "good," "fair," or "poor" according to USPSTF standards. EPC staff excluded poor-quality trials. One reviewer abstracted data from studies that were rated fair or good. A second reviewer checked all abstracted data for accuracy and completeness. EPC staff resolved discrepancies through discussion.

Data Synthesis and Analysis

EPC staff summarized all included studies in narrative form and summary tables detailing the important features of the study populations, design, intervention, and results. EPC staff used the between-group differences that were reported by authors of included studies, when available. EPC staff identified too few trials to conduct any meta-analysis, as well as too much variability in several factors (such as population or intervention). As a result, EPC staff conducted a qualitative analysis for all Key Questions (KQs) and stratified the results into 2 groups based on the intervention: primary care-based or computer-based. Primary care-based studies recruited directly from or were conducted in primary care clinics. Computer-based interventions were judged to be feasible for primary care because they used only electronic methods of delivery, although they did not recruit from or take place in primary care.

# Methods Used to Formulate the Recommendations

Balance Sheets

Expert Consensus

## Description of Methods Used to Formulate the Recommendations

The U.S. Preventive Services Task Force (USPSTF) systematically reviews the evidence concerning both the benefits and harms of widespread implementation of a preventive service. It then assesses the certainty of the evidence and the magnitude of the benefits and harms. On the basis of this assessment, the USPSTF assigns a letter grade to each preventive service signifying its recommendation about provision of the service (see Table below). An important, but often challenging, step is determining the balance between benefits and harms to estimate "net benefit" (that is, benefits minus harms).

Table 1. U.S. Preventive Services Task Force Recommendation Grid\*

Certainty of Net Benefit	Magnitude of Net Benefit			
	Substantial	Moderate	Small	Zero/Negative
High	A	B	C	D
Moderate	B	B	C	D
Low	Insufficient			

\*A, B, C, D, and I (*Insufficient*) represent the letter grades of recommendation or statement of insufficient evidence assigned by the USPSTF after assessing certainty and magnitude of net benefit of the service (see the "Rating Scheme for the Strength of the Recommendations" field).

The overarching question that the USPSTF seeks to answer for every preventive service is whether evidence suggests that provision of the service would improve health outcomes if implemented in a general primary care population. For screening topics, this standard could be met by a large randomized, controlled trial (RCT) in a representative asymptomatic population with follow-up of all members of both the group "invited for screening" and the group "not invited for screening."

Direct RCT evidence about screening is often unavailable, so the USPSTF considers indirect evidence. To guide its selection of indirect evidence, the USPSTF constructs a "chain of evidence" within an analytic framework. For each key question, the body of pertinent literature is critically appraised, focusing on the following 6 questions:

1. Do the studies have the appropriate research design to answer the key question(s)?
2. To what extent are the existing studies of high quality? (i.e., what is the internal validity?)
3. To what extent are the results of the studies generalizable to the general U.S. primary care population and situation? (i.e., what is the external validity?)
4. How many studies have been conducted that address the key question(s)? How large are the studies? (i.e., what is the precision of the evidence?)
5. How consistent are the results of the studies?
6. Are there additional factors that assist the USPSTF in drawing conclusions (e.g., presence or absence of dose–response effects, fit within a biologic model)?

The next step in the USPSTF process is to use the evidence from the key questions to assess whether there would be net benefit if the service were implemented. In 2001, the USPSTF published an article that documented its systematic processes of evidence evaluation and recommendation development. At that time, the USPSTF's overall assessment of evidence was described as good, fair, or poor. The USPSTF realized that this rating seemed to apply only to how well studies were conducted and did not fully capture all of the issues that go into an overall assessment of the evidence about net benefit. To avoid confusion, the USPSTF has changed its terminology. Whereas individual study quality will continue to be characterized as good, fair, or poor, the term certainty will now be used to describe the USPSTF's assessment of the overall body of evidence about net benefit of a preventive service and the likelihood that the assessment is correct. Certainty will be determined by considering all 6 questions listed above; the judgment about certainty will be described as high, moderate, or low.

In making its assessment of certainty about net benefit, the evaluation of the evidence from each key question plays a primary role. It is important to note that the USPSTF makes recommendations for real-world medical practice in the United States and must determine to what extent the evidence for each key question—even evidence from screening RCTs or treatment RCTs—can be applied to the general primary care population. Frequently, studies are conducted in highly selected populations under special conditions. The USPSTF must consider differences between the general primary care population and the populations studied in RCTs and make judgments about the likelihood of observing the same effect in actual practice.

It is also important to note that one of the key questions in the analytic framework refers to the potential harms of the preventive service. The USPSTF considers the evidence about the benefits and harms of preventive services separately and equally. Data about harms are often obtained from observational studies because harms observed in RCTs may not be representative of those found in usual practice and because some harms are not completely measured and reported in RCTs.

Putting the body of evidence for all key questions together as a chain, the USPSTF assesses the certainty of net benefit of a preventive service by asking the 6 major questions listed above. The USPSTF would rate a body of convincing evidence about the benefits of a service that, for example, derives from several RCTs of screening in which the estimate of benefits can be generalized to the general primary care population as "high" certainty (see the "Rating Scheme for the Strength of the Recommendations" field). The USPSTF would rate a body of evidence that was not clearly applicable to general practice or has other defects in quality, research design, or consistency of studies as "moderate" certainty. Certainty is "low" when, for example, there are gaps in the evidence linking parts of the analytic framework, when evidence to determine the harms of treatment is unavailable, or when evidence about the benefits of treatment is insufficient. Table 4 in the methodology document listed below (see the "Availability of Companion Documents" field) summarizes the current terminology used by the USPSTF to describe the critical assessment of evidence at all 3 levels: individual studies, key questions, and overall certainty of net benefit of the preventive service.

Sawaya GF, Guirguis-Blake J, LeFevre M, Harris R, Petitti D; U.S. Preventive Services Task Force. Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. *Ann Intern Med*. 2007;147(12):871-875. [5 references].

## I Statements

For I statements, the USPSTF has a new plan to commission its Evidence-based Practice Centers to collect information in 4 domains pertinent to clinical decisions about prevention and to report this information routinely. This plan is described in the paper: Petitti DB et al. Update on the methods of the U.S. Preventive Services Task Force: insufficient evidence. *Ann Intern Med*. 2009;150:199-205. <http://annals.org/article.aspx?articleid=744255>

The first domain is potential preventable burden of suffering from the condition. When evidence is insufficient, provision of an intervention designed to prevent a serious condition (such as dementia) might be viewed more favorably than provision of a service designed to prevent a condition that does not cause as much suffering (such as rash). The USPSTF recognized that "burden of suffering" is subjective and involves judgment. In clinical settings, it should be informed by patient values and concerns.

The second domain is potential harm of the intervention. When evidence is insufficient, an intervention with a large potential for harm (such as major surgery) might be viewed less favorably than an intervention with a small potential for harm (such as advice to watch less television). The USPSTF again acknowledges the subjective nature and the difficulty of assessing potential harms: for example, how bad is a "mild" stroke?

The third domain is cost—not just monetary cost, but opportunity cost, in particular the amount of time a provider spends to provide the service, the amount of time the patient spends to partake of it, and the benefits that might derive from alternative uses of the time or money for patients, clinicians, or systems. Consideration of clinician time is especially important for preventive services with only insufficient evidence because providing them could "crowd out" provision of preventive services with proven value, services for conditions that require immediate action, or services more desired by the patient. For example, a decision to routinely inspect the skin could take up the time available to discuss smoking cessation, or to address an acute problem or a minor injury that the patient considers important.

The fourth domain is current practice. This domain was chosen because it is important to clinicians for at least 2 reasons. Clinicians justifiably fear that not doing something that is done on a widespread basis in the community may lead to litigation. More important, addressing patient expectations is a crucial part of the clinician–patient relationship in terms of building trust and developing a collaborative therapeutic relationship. The consequences of not providing a service that is neither widely available nor widely used are less serious than not providing a service accepted by the medical profession and thus expected by patients. Furthermore, ingrained care practices are difficult to change, and efforts should preferentially be directed to changing those practices for which the evidence to support change is compelling.

Although the reviewers did not explicitly recognize it when these domains were chosen, the domains all involve consideration of the potential consequences—for patients, clinicians, and systems—of providing or not providing a service. Others writing about medical decision making in the face of uncertainty have suggested that the consequences of action or inaction should play a prominent role in decisions.

# Rating Scheme for the Strength of the Recommendations

What the U.S. Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer/provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer/provide this service.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer/provide this service for selected patients depending on individual circumstances.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

## USPSTF Levels of Certainty Regarding Net Benefit

Definition: The USPSTF defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	<p>The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as:</p> <ul style="list-style-type: none"><li>• The number, size, or quality of individual studies</li><li>• Inconsistency of findings across individual studies</li><li>• Limited generalizability of findings to routine primary care practice</li><li>• Lack of coherence in the chain of evidence</li></ul> <p>As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.</p>
Low	<p>The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of:</p> <ul style="list-style-type: none"><li>• The limited number or size of studies</li><li>• Important flaws in study design or methods</li><li>• Inconsistency of findings across individual studies</li><li>• Gaps in the chain of evidence</li><li>• Findings not generalizable to routine primary care practice</li><li>• A lack of information on important health outcomes</li></ul>

Level of Certainty	Description More information may allow an estimation of effects on health outcomes.
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## Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

## Method of Guideline Validation

Comparison with Guidelines from Other Groups

External Peer Review

Internal Peer Review

## Description of Method of Guideline Validation

Peer Review. Before the U.S. Preventive Services Task Force (USPSTF) makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center (EPC) and the Agency for Healthcare Research and Quality send a draft evidence review to 4 to 6 external experts and to Federal agencies and professional and disease-based health organizations with interests in the topic. The experts are asked to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the USPSTF in memo form. In this way, the USPSTF can consider these external comments before it votes on its recommendations about the service. Draft recommendation statements are then circulated for comment among reviewers representing professional societies, voluntary organizations, and Federal agencies, as well as posted on the USPSTF Web site for public comment. These comments are discussed before the final recommendations are confirmed.

Response to Public Comment. A draft version of this recommendation statement was posted for public comment on the USPSTF Web site from 1 October to 28 October 2013. All comments were reviewed and considered. Overall, most comments agreed that more evidence is needed to evaluate the effectiveness of behavioral interventions to reduce drug use. The recommendation statement was revised in response to comments seeking clarification of the terminology used and the patient population to whom the recommendation statement applies. A few comments requested that a future single recommendation statement be issued that includes alcohol, tobacco, and drug use in children and adolescents. The USPSTF currently has separate recommendation statements that address each substance and will consider concurrently updating recommendation statements that pertain to screening and interventions for all 3 areas in the future.

Comparison with Guidelines from Other Groups. Recommendations for screening from the following groups were discussed: the American Academy of Pediatrics and the American Academy of Family Physicians.

## Evidence Supporting the Recommendations

### Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

## Benefits/Harms of Implementing the Guideline Recommendations

### Potential Benefits

Benefits of Behavioral Interventions

The U.S. Preventive Services Task Force (USPSTF) found inadequate evidence about the effect of behavioral interventions to reduce drug use on

health outcomes in adolescents. It also found inadequate evidence about the effect of behavioral interventions to reduce initiation of drug use in adolescents. The USPSTF found no evidence about behavioral interventions for children younger than age 11 years.

## Potential Harms

### Harms of Behavioral Interventions

The U.S. Preventive Services Task Force (USPSTF) found no studies about the magnitude of the harms of behavioral interventions to prevent or reduce drug use. Although the USPSTF recognizes that theoretical harms, such as the potential to increase drug initiation through a false sense of security, may exist, it concludes that the harms of behavioral interventions are probably small to none.

## Qualifying Statements

### Qualifying Statements

- The U.S. Preventive Services Task Force (USPSTF) makes recommendations about the effectiveness of specific clinical preventive services for patients without related signs or symptoms.
- It bases its recommendations on the evidence of both the benefits and harms of the service and an assessment of the balance. The USPSTF does not consider the costs of providing a service in this assessment.
- The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation. Similarly, the USPSTF notes that policy and coverage decisions involve considerations in addition to the evidence of clinical benefits and harms.
- Recommendations made by the USPSTF are independent of the U.S. government. They should not be construed as an official position of the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services.

## Implementation of the Guideline

### Description of Implementation Strategy

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the USPSTF will make all its products available through its [Web site](#) . The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access USPSTF materials and adapt them for their local needs. Online access to USPSTF products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major

challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

## Implementation Tools

Mobile Device Resources

Patient Resources

Pocket Guide/Reference Cards

Staff Training/Competency Material

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

## Institute of Medicine (IOM) National Healthcare Quality Report Categories

### IOM Care Need

Staying Healthy

### IOM Domain

Effectiveness

Patient-centeredness

## Identifying Information and Availability

### Bibliographic Source(s)

U.S. Preventive Services Task Force. Primary care behavioral interventions to reduce illicit drug and nonmedical pharmaceutical use in children and adolescents: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med.* 2014 May 6;160(9):634-9. [12 references] [PubMed](#)

### Adaptation

Not applicable: The guideline was not adapted from another source.

### Date Released

1996 (revised 2014 May 6)

### Guideline Developer(s)

U.S. Preventive Services Task Force - Independent Expert Panel

## Guideline Developer Comment

The U.S. Preventive Services Task Force (USPSTF) is a federally-appointed panel of independent experts. Conclusions of the USPSTF do not necessarily reflect policy of the U.S. Department of Health and Human Services or its agencies.

## Source(s) of Funding

The U.S. Preventive Services Task Force (USPSTF) is an independent, voluntary body. The U.S. Congress mandates that the Agency for Healthcare Research and Quality support the operations of the USPSTF.

## Guideline Committee

U.S. Preventive Services Task Force

## Composition of Group That Authored the Guideline

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*\*Members of the Task Force at the time this recommendation was finalized. For a list of current Task Force members, go to <http://www.uspreventiveservicestaskforce.org/Page/Name/our-members> .*

## Financial Disclosures/Conflicts of Interest

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Disclosures: Dr. Moyer: *Support for travel to meetings for the study or other purposes*: AHRQ. Dr. Owens: *Support for travel to meetings for the study or other purposes*: USPSTF. Authors not named here have disclosed no conflicts of interest. Authors followed the policy regarding conflicts of interest described at <http://www.uspreventiveservicestaskforce.org/Page/Name/procedure-manual---section-1>

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## Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: U.S. Preventive Services Task Force (USPSTF). Screening for illicit drug use: U.S. Preventive Services Task Force recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2008 Jan. 7 p.

This guideline meets NGC's 2013 (revised) inclusion criteria.

## Guideline Availability

Electronic copies: Available from the [Annals of Internal Medicine Web site](#) .

## Availability of Companion Documents

The following are available:

Evidence Reviews:

- Patnode CD, O'Connor E, Rowland M, Burda BU, Perdue LA, Whitlock EP. Primary care behavioral interventions to prevent or reduce illicit drug use and nonmedical pharmaceutical use in children and adolescents: a systematic evidence review for the U.S. Preventive Services Task Force. *Ann Intern Med*. 2014 May 6;160(9):612-20.
- Patnode CD, O'Connor E, Rowland M, Burda BU, Perdue LA, Whitlock EP. Primary care behavioral interventions to prevent or reduce illicit drug and nonmedical pharmaceutical use in children and adolescents: A systematic evidence review for the U.S. Preventive Services Task Force. Evidence Synthesis No. 106. AHRQ Publication No. 13-05177-EF-1. Rockville (MD): Agency for Healthcare Research and Quality; 2014 Mar. 75 p.

Electronic copies: Available from the [U.S. Preventive Services \(USPSTF\) Web site](#) .

Background Articles:

- Barton MB et al. How to read the new recommendation statement: methods update from the U.S. Preventive Services Task Force. *Ann Intern Med* 2007;147:123-127.
- Guirguis-Blake J et al. Current processes of the U.S. Preventive Services Task Force: refining evidence-based recommendation development. *Ann Intern Med* 2007;147:117-122.
- Sawaya GF et al. Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. *Ann Intern Med* 2007;147:871-875.
- Petitti DB et al. Update on the methods of the U.S. Preventive Services Task Force: insufficient evidence. *Ann Intern Med*. 2009;150:199-205.

Electronic copies: Available from [USPSTF Web site](#) .

The following are also available:

- The guide to clinical preventive services, 2014. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2014. 144 p. Electronic copies available from the [AHRQ Web site](#) . See the related QualityTool summary on the [Health Care Innovations Exchange Web site](#) .
- Primary care behavioral interventions to reduce illicit drug and nonmedical pharmaceutical use in children and adolescents: clinical summary of U.S. Preventive Services Task Force recommendation. 2014 Mar. 1 p. Electronic copies: Available from the [USPSTF Web site](#) .
- A continuing medical education (CME) activity is available from the [Annals of Internal Medicine Web site](#) .

The [Electronic Preventive Services Selector \(ePSS\)](#)  is an application designed to provide primary care clinicians and health care teams timely decision support regarding appropriate screening, counseling, and preventive services for their patients. It is based on the current, evidence-based recommendations of the USPSTF and can be searched by specific patient characteristics, such as age, sex, and selected behavioral risk factors.

## Patient Resources

The following is available:

- Primary care interventions to reduce drug use in children and adolescents: U.S. Preventive Services Task Force Recommendation Statement. Summary for patients. *Ann Intern Med*. 2014;160(9):I-24 Electronic copies: Available from the [Annals of Internal Medicine Web site](#) .

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/research/publications/index.html>  or call 1-800-358-9295 (U.S. only).

Myhealthfinder is a tool that provides personalized recommendations for clinical preventive services specific to the user's age, gender, and pregnancy status. It features evidence-based recommendations from the USPSTF and is available at [www.healthfinder.gov](http://www.healthfinder.gov)

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

## NGC Status

This NGC summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998. This NGC summary was updated by ECRI Institute on January 15, 2008. The updated information was verified by the guideline developer on January 17, 2008. This summary was updated by ECRI Institute on June 6, 2014.

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